MUH Ethics Committee DISASTER TRIAGE Policy

Walter Limehouse MD
MUSC Emergency Medicine

Disaster triage planning

- Ethical principles first
  - apply to all-disaster triage
- Technical considerations follow
  - survival probabilities
  - resource estimates

Ethical Framework for Disaster Triage

- Duty to care
- Duty to steward resources
- Duty to plan
- Distributive Justice
- Transparency

Duty to Care

- Respect fundamental obligation of health care professionals to care for patients.
  - to treat as many patients and save as many the patient lives as possible.

Duty to Care

- Health professionals offer bedside care
  - to individual patients, not to populations.
  - system sustains patient-provider relationship
  - physicians must not abandon
    - patients should not fear abandonment
  - patients not eligible for mechanical ventilation
    - receive other curative and/or palliative treatment

Duty to Care

- United States
  - preferences of capable patients generally govern whether or not to start recommended treatments.
  - pandemic
    - patient preference cannot determine rationing of ventilators
    - demand will far exceed the available number
    - resource scarcity limits decision-making autonomy for patients and providers.
    - Allocation guidelines must reflect those limits.

Duty to Care

- Just rationing scheme
  - supports autonomy, when possible,
  - honors the duties of care and stewardship.
- Guidelines stress provision of care possible when ventilation is not
  - other treatment or palliative measures for patients denied access to ventilators.

Duty to steward resources

- Government & health care providers
  - must steward resources during true scarcity.
  - obligation to all patients must balance primary duty to care for each patient

Duty to steward resources

- ordinary circumstances,
  - critical care providers question
    - estimated benefit of an intervention vs use of scarce resources
- disaster on scale of severe pandemic
  - magnifies such limits.
  - Patients who might survive under ordinary circumstances
    - will not receive the ordinary level of resources,
    - may die without any resources.

Duty to steward resources

- disaster on scale of severe pandemic
  - Clinicians balance obligations
    - save the greatest possible number of lives
    - care for each patient.
  - As number of affected patients increases accommodating these two goals requires more and more difficult decisions.

Duty to Plan

- Obligation to exhausted, front-line providers
- Failure to produce acceptable guidelines for foreseeable crisis
  - failure of responsibility toward both patients and providers..
- Appropriate guidelines may prevent
  - actual or feared legal consequences for providing emergent care

Duty to Plan

- planning obligatory, but any guidelines devised imperfect
  - current access to health care is unequal;
    - no rationing system for crisis resolves inequities in pre-existing health status
  - clinical parameters of a pandemic uncertain,
    - increases difficulty of predicting survival or duration of critical symptoms.
    - planning still vital

Distributive Justice

- just system of allocation must be applied broadly in order to be fair.
  - state uses same allocation system & authorizes decision to implement rationing.
  - Timing and content of just rationing systems cannot be hospital-based,
    - must be coordinated within the community,
    - among communities
    - between the local communities and the State

Distributive Justice

- just or equitable healthcare system
  - equal access at private facility , community or public hospital.
- Cooperative agreements to pool scarce resources
  - among local hospitals may help alleviate shortages
  - allocation of ventilators from state and federal stockpiles
    - account for ratio of local populations to available resources
    - Supplement resources accordingly.

Distributive Justice

- sound disaster response does not exacerbate disparities in access to care.
  - planners designate appropriate resources for most vulnerable
    - most likely to suffer greatest impact in any disaster.

Transparency

- **Any just system of allocating ventilators requires transparency,**
  - seeking broad input in design of the system
  - educating the public about the evolving plan.
- **The state should publicize proposed guidelines**
  - translate them into different languages as necessary
  - share them with health care leaders and the community
  - include historically underserved communities.
- **After assessing comments,**
  - **plan revisions should assure just allocation process.**

Transparency

- Disaster planning must not serve as a covert means to resolve long-standing problems in health care.
  - rationing system does not alleviate the need to provide adequate resources.
  - rationing may lead to acceptance of a lack of resources without challenging the scarcity.
- Just system seeks to avoid rationing
  - purchase and use of supplemental ventilators, cancellation of elective surgeries, and altered standards of care for staffing ratios.
- State should invoke triage
  - during situations of true scarcity.
- Guidelines must reflect our common duty to protect the rights of the disabled

Transparency:

- Parameters for allocation system for ventilators
  - Clinicians will remove from ventilators
    - patients with the highest probability of mortality
    - to benefit patients with a high likelihood of survival.
  - extubating less ill patients from ventilators
    - particularly those who might recover with continued mechanical ventilation, problematic.

Transparency:

- Guidelines should minimize required patient extubation
  - Clinicians & family members will be reluctant to withdraw ventilators from patients.
  - Heavy reliance on withdrawal of ventilators
    - generates concern, controversy, and may be set aside in an emergency.
    - withdrawing ventilation and observing the subsequent demise of patients will be traumatic for all concerned, including clinicians.
    - withdrawal of ventilation without patient consent raises significant liability issues;
- Appropriate guidelines will limit instances of tragic choices [1, 2].

MUH Ethics Committee Disaster Policy

- We endorse the *Ontario Health Plan for an Influenza Pandemic (OHPIP)* as a general model for resource allocation, although particular to influenza.

MUH Ethics Committee Disaster Policy

- We specifically support the concepts
  - (1) disaster triage officers should make allocation decisions based upon clinical decision rules, with separate medical personnel rendering treatment,
  - (2) triage & treatment roles should rotate to avoid bias in triage decisions,
  - (3) development of clinical decision rules during all-disaster planning requires transparency & public endorsement,

MUH Ethics Committee Disaster Policy

- We specifically support the concepts
  - (4) while health professionals have a moral duty to treat during disasters, institutions have an equal obligation to provide appropriate personal protective equipment and all-disaster training,
  - (5) obligatory service by health care professionals during disasters should be openly negotiated among available providers [3, 4, 5].

Bibliography

- [1] L. Rubinson, et al. “Augmentation of hospital critical care capacity after bioterrorist attacks or epidemics: Recommendations of the Working Group on Emergency Mass Critical Care,” *Critical Care Medicine,* 2005, 33(10):E1-13.
- [2] NYS Workgroup on Ventilator Allocation in an Influenza Pandemic, Allocation of Ventilators in an Influenza Pandemic: Planning Document NYS DOH/ NYS Task Force on Life & the Law, March 2007
- [3] University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group, “Stand on Guard for Thee: Ethical considerations in preparedness planning for pandemic influenza,” November 2005
- [4] J. D. Arras, “Ethical Issues in the Distribution of Influenza Vaccines,” *Hastings Center Report*, In Press.
- [5] KV Iserson, “Fight or Fight: The Ethics of Emergency Physician Disaster Response,” Annals of Emergency Medicine, 2008, 51 (4): 345-353.